MINUTES

JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON MENTAL HEALTH, DEVELOPMENTAL DISABILITIES AND SUBSTANCE ABUSE SERVICES

Wednesday, October 4, 2006
9:30 AM
Room 643, Legislative Office Building

The Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities and Substance Abuse Services met on Wednesday, October 4, 2006, at 9:30 A.M. in Room 643 of the Legislative Office Building. Members present were Senator Martin Nesbitt, Co-Chair; Representative Verla Insko, Co-Chair; Senators Austin Allran, Janet Cowell, and William Purcell and Representatives Jeff Barnhart, Beverly Earle, Bob England, Edd Nye, and Fred Steen. Advisory members, Senator Larry Shaw and Representatives Jean Farmer-Butterfield and Earline Parmon were present.

Kory Goldsmith, Shawn Parker, Andrea Russo, Natalie Towns and Rennie Hobby provided staff support to the meeting. Attached is the Visitor Registration Sheet that is made a part of the minutes. (See Attachment No. 1)

Senator Martin Nesbitt, Co-Chair, called the meeting to order, welcoming members and guests. The committee was asked for a motion to approve the minutes from the September 6, 2006 meeting. Representative Parmon made the motion and the minutes were approved.

Senator Nesbitt informed members that the November meeting date had been changed to Monday, November 13th at 10:00 in Room 643 of the Legislative Office Building. On a personal note, he said that Western Highlands, which serves 8 counties in the mountains, was closing. He said that there had been financial difficulty for some time, but thanks to good leadership, the employees and clients were being placed with other providers. He also said that funding approved last session was helping to provide services.

Representative Insko recognized that this was Mental Illness Awareness week. She also said that a clubhouse in the Western Highlands area was in danger of failing due to a lien on the building. She said that it was a stable clubhouse serving 100 mentally ill people. She said representatives of the clubhouse would be in the audience today and was hopeful that they might connect with someone that might be able to offer assistance.

Kory Goldsmith reviewed legislation requiring the Department of Health and Human Services to study the long-term plan for meeting the mental health, developmental disabilities, and substance abuse services needs. (See Attachment No. 2) The report to be heard today is the preliminary report with the final report to be delivered in December.

Steve Hairston, Section Chief for Operations Support with the Division on MHDDSAS, introduced consultant Dr. Christina Thompson of Heart of the Matter Consulting, Inc., who presented the preliminary report on the Long Range Study for MHDDSAS and Service Gaps. (See Attachment No. 3) Dr. Thompson explained that to complete the draft report, a statistical picture of service delivery in North Carolina was taken as it is currently and then projected into the future using technology and statistical modeling.

This method is called Stochastiz Modeling. She said that the report looks at what the needs are, whether or not the current funds are sufficient, and what is needed to meet the needs in the State. She said that there were three options if funding was not sufficient: 1) require utilization of lower cost service and prioritize services for higher need consumers; 2) provide additional funds; and 3) cut services or exclude populations. Dr. Thompson explained that they used submitted data from SFY 2005 which incorporated all outstanding claims paid through May 2006. She said the data did not include services purchased with local dollars because it is not required by the State. She added that North Carolina should try to collect this information since the State may now be meeting needs statewide but not be aware of it since this local data is not recorded. Dr. Thompson encouraged the State to collect data on emergency services and waiting list measurements, as neither are currently available.

Dr. Thompson explained how the statistical models were created and reviewed the formula used. Statistical models were created for use with each specific service, each disability group, each age group, and each funding source. The three models are: 1) Actual Model – calibrated to correspond to FY 2005 service use and cost patterns; 2) Evidenced Best Practice Model – a prospective model based on the Actual Model that brings North Carolina up to the national average for treated prevalence across populations, increase continuity of service, and reduce State Facility use; and 3) Defined Benefit Model – designed to reflect a minimum set of services and limits on service units that could be used to project costs in serving the non-Medicaid population in North Carolina. She said that one of the biggest problems in North Carolina was the treated prevalence rate. Compared to national data, North Carolina's rate is higher than the national average. Mental health and substance abuse are below the national treated prevalence while other disabilities are higher. She also said that in order to get good outcomes it was important to improve continuity, since North Carolina is below average in treatment continuity for the MH and SA populations. Dr. Thompson reviewed several maps of North Carolina using data from 2005 to detail specific analysis of data. She said that the prospective models raised the prevalence rate, increased continuity, increased Evidence Best Practice (EBP) and service intensity, included numbers for population growth, increased the cost of services, included the people served, and the annual monthly caseloads. Other charts showed the summary of the total of community-based services, facilities and global allocations and a chart comparing the 2005 Actual Model, the Defined Benefit Model, and the EBP Model.

Dr. Thompson said that a preliminary estimate of funding for services needed to bring North Carolina up to the national average over a five year period of time beginning in 2005 was $550 million in total State and Medicaid dollars. Approximately $100 million dollars would be needed each year. Additional funding would be needed for those not in the target population. She said that North Carolina was below the national average in terms of the number of people that are disabled who are eligible for Medicaid. One problem is the Medicaid State Plan and the poverty level. The State Plan could be amended to allow more to become eligible for Medicaid. Dr. Thompson was asked about Medicaid dollars for people with substance abuse issues. People with just substance abuse disorders are not likely to qualify for Medicaid unless they have a dual diagnosis. She suggested looking at the poverty level and also suggested filing an Adult Benefit Waiver which would serve people with less severe problems. Suggestions to reduce the impact of $110 million per year were the reduction of State facilities, increase Medicaid

eligibles, buy-in to Medicaid for certain groups of people, statewide ability to pay, and room and board. With these reductions, the State could be looking at $19 - $20 million per year. The Department was asked to make recommendations in December to the committee. Mr. Moseley, Director of the Division on MHDDSAS, said that the committee needed to be aware that policy considerations would need to be made. Dr. Thompson said that State Facilities should be downsized further and that it should be done faster because there were people there who could be served better in the community. Diverting substance abuse admissions to detox facilities would be a big savings to the State. She said several key recommendations included the importance of having policy parameters and the need to put as many policies as possible in administrative rules so that they are consistent across the State, and that North Carolina needed an information system infrastructure capable of capturing all the data. The final report due in December will contain approximately 50 recommendations. Committee members asked that recommended legislation be included in the report.

Members questioned the need for 2 new hospitals. It was suggested that the General Assembly may want to look at how large the hospitals should be. It was noted that more resources at the State level are necessary to build community capacity and for training and technical assistance in the community. Staff was asked to see what types of services are provided to those individuals with mental illness in prisons.

Next, Senator Nesbitt asked Kory Goldsmith, Research Division, and Andrea Russo, Fiscal Research, to review follow-up questions from the September LOC meeting. They reviewed a packet of information assembled to address concerns of the last meeting. (See Attachment No. 4) Ms. Goldsmith specifically suggested that the committee review the semi-annual report on *Statewide System Performance* which looks at a number of measures of how the system is performing. Ms. Wainwright explained that the second chart on page 9, only related to persons served in the community and does not reflect those served in State facilities. She said that LMEs in the larger counties were not required to report to the State the units of service purchased using county dollars. The committee requested that an estimate be reported in order to see where the State ranks. It was also requested that information be gathered from other states looking at their system and process used to depopulate State facilities – if it was cost effective, the rate at which it was done, and if all facilities were closed or if some were left open.

After lunch, Dr. Bonnie Morrell, Team Leader for the Best Practice Team from the Division on MHDDSAS, gave an in-depth description of services for the mentally ill. (See Attachment No. 5) She began by reviewing the principals guiding the service system, and discussing services for children and adults. The philosophy that underlines the service system is based on providing prevention, intervention, treatment, services, and support that will help people with serious problems be successful in their communities. She said the system must engage the consumer in determining proper services and those clinical needs are carefully assessed so that professional recommendations regarding services can meet those needs.

In addressing services for children, Dr. Morrell said that services were built on a framework system of care which is a nationally strength-based framework that develops partnerships with individuals and the families that need services and the resources and agencies that can help address those needs. She reviewed the new and recently approved

revised Medicaid services and said that the State pays for the services for those who do not have Medicaid. Dr. Morrell then explained Diagnostic Assessment stating that the assessment was done by 2 professionals (a licensed psychologist, physician, psychiatric nurse practitioner, and a licensed professional in the disability area needed) at a rate of $169.00 per assessment. Community Services are arranged in such a way as to allow immediate engagement with the family while the Diagnostic Assessment is being completed, and while the PCP is being developed. The staff providing the service has the responsibility of being the first responder.

Dr. Morrell then explained a new service called Intensive In-Home Service, which is a time limited service that helps a child be successful in home when they are at risk of not being able to stay there. Professional staff works with the family intensively for a period up to 3 months, at a cost of $190 per day for at least 2 hours of service. Another new service, Multisystemic Therapy (MST), is designed for youths with aggression and violent behaviors. MST coordinates the services of multiple agencies, and includes specialized training and supervision requirements. She said it had been very effective in helping children remain in the community. This service is billed on a 15 minute unit of time at $23.54 per unit. The last new service she highlighted was Mobile Crisis. She said a team of professionals trained in crisis intervention strategies with at least 1 year of experience would evaluate, stabilize the crisis, and triage the person to ongoing services if they are needed.

Dr. Morrell then explained the process a family goes through in selecting a Community Support Provider. The Provider arranges a diagnostic assessment and provides immediate support while working with the child and family team on developing a service plan within 30 days. Once a treatment is decided upon, the Community Support Provider will remain in contact with the child and family. She then described several children and the kinds of needs these children had that could be addressed by various services.

Next, Dr. Morrell addressed adults with serious mental illness. She explained that the key to success was the engagement of the individual, treatment and strategies to manage the illness, and moving toward having hope and recovery focused efforts in the community. She said that while many of the new services were similar to the child services, Community Support for adults is more intensive, focuses on education for the consumer about the illness, engaging them to understand the symptoms, and monitoring them. Case management includes professionals and paraprofessionals who are responsible as first responders. Assertive Community Treatment was modified to bring it up to Evidence Best Practice standards with a focus on adults with mental illness. Psychosocial Rehabilitation was modified to require daily service notes rather than monthly notes in response to requirements set by the Centers for Medicaid and Medicare Services (CMS). She said that it was unlikely that a change back to monthly notes would be approved. Medicaid is looking at the current rate of $2.43 per 15 minutes, ($9.36 per hour) per person. Medicaid will be looking to see if the rate reflects the actual cost; what the additional cost of the change is in documentation requirements; what the implication is of the expectation that psychosocial rehab programs get national accreditation within 3 years; and what the expectation is regarding transportation being built into the rate. Leza Wainwright, Deputy Director of the Division on MHDDSAS, was asked what providers needed to do in preparing for the possible rate increase. She responded that the Department had developed a rate model in the past that CMS would accept. CMS wants

to see actual cost data from actual providers so providers need to register with the provider data base maintained on the Division of MHDDSAS website. The Division will select approximately 10 psychosocial rehabilitation providers across the State, and ask those providers to provide 3 to 6 months of actual cost data to put into a rate analysis to be given to CMS.

Next, Leza Wainwright provided an update on the Mental Health Trust Fund allocations. She explained the plan for the use of funds during SFY 2007. (See Attachment No. 6) She said that the plan outlined the use of a total amount available of $33,213,159. She said that every item listed were basically the same types of items that the Trust Fund had used in the plan approved last year.

Secretary Carmen Hooker Odom, Department of Health and Human Services, addressed the shortfall in LME administration funds. (See Attachment No. 7) She said that Medicaid is a $9 billion enterprise and MHDDSAS is a $2 billion enterprise, but more money is spent on administration for MHDDSAS than for Medicaid. She said that it was imperative to right-size the administrative costs. She explained several issues that contributed to funding shortfalls and items being faced this fiscal year. Secretary Hooker Odom said that because the Department never receives the funding necessary to fund operations from year to year, it is necessary to look at every line item in the Department budget to secure funds to cover the shortfalls and emergencies. She said that the Division currently had a $51.2 million shortfall, including $18.9 million for LME Systems Management. She said the State bears full responsibility for the administrative cost for running the system. The Division was instructed to find the $18.9 million shortfall within the Division. She said that there were no reductions from 2006 actual expenditures in the funds put together to meet the shortfall. The Secretary said that the new cost model would provide an adequate and appropriate administrative amount for the system. She was asked to provide a list of the shortfalls.

Ms. Wainwright identified 8 areas of funding used to address the shortfall. (See Attachment No. 8) She said that the Department was not anticipating that these cuts would be permanent. Total funds identified were $19.5 million, leaving a reserve of $594,000. The proposed cuts are subject to approval by the Department and the Budget Office.

There being no further business, the meeting adjourned at 3:15 PM.

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Senator Martin Nesbitt, Co-Chair Representative Verla Insko, Co-Chair

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Rennie Hobby, Committee Assistant